



## SERVICE USER REFERRAL FORM

<b>DETAILS OF THE PERSON BEING REFERRED</b> Forename: Surname: Address:  Date of birth: Male <input type="checkbox"/> Female <input type="checkbox"/> Telephone number: Mobile Number:  Is service user aware of the referral? Y <input type="checkbox"/> N <input type="checkbox"/>	<b>DETAILS OF REFERRER</b> Referrers Name: Job title:  Name of referring organisation:  Address:  Telephone number: Email address:  Wish to be kept informed? Y <input type="checkbox"/> N <input type="checkbox"/>
<b>DATE OF REFERRAL:</b>	
<b>CONSENT</b> Is it ok to send mail/text/email? Y <input type="checkbox"/> N <input type="checkbox"/>  Is it ok to call/leave message? Y <input type="checkbox"/> N <input type="checkbox"/>	GP Name  GP Address  GP Telephone:
<b>WHAT SERVICE/SUPPORT IS REQUIRED?</b> <input type="checkbox"/> Cocaine Evening Programme <input type="checkbox"/> Community Detoxification Support <input type="checkbox"/> One to one support work <input type="checkbox"/> Assistance to access detox/residential facility <input type="checkbox"/> Pre Entry Programme <input type="checkbox"/> Medically Assisted Recovery programme <input type="checkbox"/> Drug Free Programme	<b>PRESENTING PROBLEM (PLEASE TICK):</b> <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Drug Use <input type="checkbox"/> Alcohol & Drug Use <input type="checkbox"/> Drug use and gambling <input type="checkbox"/> Alcohol use and gambling <input type="checkbox"/> Cocaine (as primary substance)
<b>CURRENT DRUG USE WITH DATE OF MOST RECENT SUBSTANCE MISUSE:</b>	<b>CURRENT PRESCRIPTION MEDICATION AND PRESCRIBER:</b>
<b>AREAS OF RISK</b> <input type="checkbox"/> Responsible for children <input type="checkbox"/> Pregnancy <input type="checkbox"/> Domestic violence <input type="checkbox"/> Violence/aggression <input type="checkbox"/> Currently IV drug use <input type="checkbox"/> Sharing equipment	<input type="checkbox"/> Homeless/at risk? <input type="checkbox"/> Recently released from prison <input type="checkbox"/> Due to be released from prison <input type="checkbox"/> Challenging behaviour <input type="checkbox"/> Self harm <input type="checkbox"/> Other _____
<b>WAS A RISK ASSESSMENT COMPLETED?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known <input type="checkbox"/> IF YES PLEASE SPECIFY AND/OR PLEASE PROVIDE ANY RELEVANT REPORTS	

**ANY RELEVANT DIAGNOSIS PHYSICAL/MENTAL HEALTH PROBLEMS (DISABLED, POOR MOBILITY, PSYCHOSIS, OTHER ACCESSIBILITY ISSUES ETC.)**

**LEGAL ISSUES IF KNOWN**

- None
- On Probation
- On Probation with condition to attend
- Cases Pending  
Court dates & charges
- Awaiting Sentence
- Other

**PLEASE PROVIDE ANY OTHER RELEVANT INFORMATION, INCLUDING:**

- Brief history of the problem
- Involvement with any other services
- Housing situation
- Is the service user ready to attend our services

**FAMILY INVOLVEMENT/CONCERNED PERSONS**

CONCERNED PERSON'S NAME	RELATIONSHIP TYPE	PHONE NUMBER

**HOW DID YOU HEAR ABOUT OUR SERVICE**

**COMPLETED REFERRAL FORMS SHOULD BE RETURNED BY POST OR EMAIL, MARKED PRIVATE & CONFIDENTIAL TO:**  
ANTHEA CARRY | DUN LAOGHAIRE RATHDOWN OUTREACH PROJECT | 45 UPPER GEORGES STREET, DUN LAOGHAIRE,  
CO. DUBLIN | [MANAGER@DROP.IE](mailto:MANAGER@DROP.IE)

**OFFICE USE ONLY (to be completed by member of intake team)**

Service User Name:	DOB:	<input type="checkbox"/> Referral entered into eCASS <b>Client Reference No:</b>
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Date referral Received:	Initial Contact made with service user Yes <input type="checkbox"/> No <input type="checkbox"/> Date of motivation assessment: _____ Date of Initial Assessment: _____
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<input type="checkbox"/> New Referral <input type="checkbox"/> Re-referral within 6 months <input type="checkbox"/> Re-referral outside 6 months
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<input type="checkbox"/> Accepted <input type="checkbox"/> Not suitable, Reason:
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<input type="checkbox"/> Allocated to: <input type="checkbox"/> Date Allocated:
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<input type="checkbox"/> Transferred Date of Transfer: _____ <input type="checkbox"/> Service transferred to:
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WAITING LIST Date placed on waiting list _____ Number on Waiting list _____ Most suitable day/time _____ _____
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Unavailable for assessment from _____ To _____ (dates) Reason for unavailability: <input type="checkbox"/> Legal <input type="checkbox"/> Medical <input type="checkbox"/> Social
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<input type="checkbox"/> Referral form uploaded to eCASS <input type="checkbox"/> Initial Assessment details input to eCASS <input type="checkbox"/> Privacy Statement Signed & uploaded to eCASS
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ADDITIONAL NOTES
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